ILLINOIS WORKERS' COMPENSATION COMMISSION
APPLICATION FOR SELF-INSURANCE

Read all instructions before completing this application. Answer all questions.

RETURN TO:	APPLICANT'S LEGAL NAME/MAILING ADDRESS/WEB SITE	DESIRED SELF-INSURANCE EFFECTIVE DATE:
Office of Self-Insurance Admin. 701 S. Second St. Springfield, IL 62704		

The employer (applicant) applies for the privilege of being a certified self-insurer in the State of Illinois, as provided in the Illinois Workers' Compensation and Occupational Diseases Acts. An applicant may not operate as a certified self-insurer until the Commission issues a *Certificate of Approval to Self-Insure*.

1. LIST THE COMPANY REPRESENTATIVE FOR SELF-INSURANCE.

Name		Title	
Company name			
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			

2. APPLICANT'S FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	
3. STATUS:	Individual ☐ Partnership ☐ Corporation ☐
4. NATURE OF BUSINESS	

Primary NAICS codes				

NAICS = North American Industry Classification System, which replaces SIC.

5. INCORPORATED OR ORGANIZED UNDER THE LAWS OF THE STATE OF		ON	
6. DATE OF COMMENCEMENT OF BUSINESS IN ILLINOIS			

7. IF THE APPLICANT IS A SUBSIDIARY, COMPLETE THE FOLLOWING ITEMS.

Exact legal name of *ultimate parent*			
Date parent incorporated		State	
FEIN		Web site	

8. LIST THE CORPORATE PRINCIPALS FOR THE ULTIMATE PARENT OR APPLICANT IF NO PARENT. *If necessary, attach a list.*

NAME	TITLE	STREET ADDRESS, CITY, STATE, ZIP	TELEPHONE

9. LIST THE SUBSIDIARIES OR AFFILIATES TO BE INCLUDED IN THE SELF-INSURANCE PROGRAM. *If necessary, attach a list.*

LEGAL NAME	DATE OF INCORP.	STREET ADDRESS, CITY, STATE, ZIP	FEIN	NAICS CODE	NATURE OF BUSINESS	SUB. OR AFF.?

10. LIST THE PHYSICAL LOCATIONS OF EACH OPERATION TO BE SELF-INSURED. *If attaching a list, follow the same format.*

OPERATION NAME AND ADDRESS	FEIN	NAICS CODE	NATURE OF BUSINESS	AVERAGE # OF EMPLOYEES IN	
				PRODUCTION	OFFICE/SALES

11. LIST THE NAME OF CURRENT WORKERS' COMPENSATION INSURANCE CARRIER.

Name					
Policy number		Effective dates: From		to	

Provide evidence of applicant's current workers' compensation coverage.

12. INDICATE THE ESTIMATED ANNUAL WORKERS' COMPENSATION PREMIUM FOR THE LAST COMPLETED CALENDAR YEAR. INCLUDE THE PREMIUM OF ALL SUBSIDIARIES TO BE COVERED BY SELF-INSURANCE IN ILLINOIS.
If necessary, attach a list.

INSURANCE CLASS CODE	INSURANCE CLASSIFICATION DESCRIPTION	# EMPLOYEES	EST. ANNUAL PAYROLL	CURRENT MANUAL RATE	EST. ANNUAL PREMIUM
TOTAL					

13. PROVIDE THE FOLLOWING CLAIMS INFORMATION FOR YOUR PROPOSED SELF-INSURED OPERATIONS IN ILLINOIS FOR THE LAST THREE COMPLETED YEARS. *Attach detailed loss runs for the last three completed years.*

	YEAR ENDING	YEAR ENDING	YEAR ENDING
A. Number of accidents requiring only medical attention			
B. Number of accidents requiring lost time of more than 3 days			
C. Total paid claims			
D. Outstanding reserves (incl. medical, indemnity, & expenses) *If the reserves vary by more than 20% during these years, provide an explanation.*			
E. Total incurred losses (paid and reserves)			
F. Number of fatalities			

Attach a description of each fatality, including the employee's name, date of accident, cause of accident, current status of the claim, and the outcome of any OSHA investigation and/or citations relating to the fatality.

14. LIST THE PERSON TO WHOM INFORMATION REGARDING ASSESSMENTS FOR THE SELF-INSURERS SECURITY FUND, SECOND INJURY FUND, RATE ADJUSTMENT FUND. AND OPERATIONS FUND SHOULD BE SENT.

Contact person		Title	
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			

15. LIST THE NAME OF THE PROPOSED CLAIMS SERVICE AGENCY.

Company name			
Contact person		Title	
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			

16. IF YOU DO NOT PLAN TO RETAIN A CLAIMS SERVICE AGENCY, LIST THE COMPANY REPRESENTATIVE WHO WILL BE RESPONSIBLE FOR THE SELF-INSURANCE PROGRAM.

Contact person		Title	
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			
Describe the experience and qualifications of this person.			

17. LIST THE DESIGNATED SAFETY REPRESENTATIVE.

Name		Title	
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			

Attach a narrative description of the safety and loss control program components for your operations in Illinois. Do not send a manual.

18. WHAT MEDICAL FACILITIES ARE AVAILABLE TO YOUR EMPLOYEES? First aid ☐ In-plant doctor/nurse ☐ Local clinic ☐ Hospital ☐ Other ☐ (please explain)

19. IF ANY OF THE APPLICANT'S EMPLOYEES HAVE EXPOSURE IN ANY DEGREE TO SUBSTANCES THAT MAY CAUSE OCCUPATIONAL DISEASE, INDICATE THE SUBSTANCE AND APPROXIMATE PERCENTAGE OF EMPLOYEES EXPOSED.
If necessary, attach a list. Include asbestos, silica dusts, any toxic, injurious, or hazardous substances, compounds, or chemicals, caustics, fumes, noise, radiation, communicable diseases, and any other occupational disease exposures.

SUBSTANCE	PERCENTAGE OF EMPLOYEES EXPOSED	# ACCIDENT REPORTS FILED

20. HAS AN APPLICATION FOR WORKERS' COMPENSATION INSURANCE EVER BEEN REFUSED OR A POLICY CANCELLED? Yes ☐ No ☐
If yes, attach an explanation of circumstances, including the date, jurisdiction, and carrier.

21. HAS AN APPLICATION FOR SELF-INSURANCE EVER BEEN DENIED OR A CERTIFICATION REVOKED? Yes ☐ No ☐
If yes, attach an explanation of circumstances, including the date and jurisdiction.

22. IS THE APPLICANT SELF-INSURED IN ANY OTHER JURISDICTION? Yes ☐ No ☐
If yes, attach a list of jurisdictions.

23. IF THE APPLICANT IS RATED, PROVIDE THE LATEST RATINGS, INCLUDING THE DATE OF THE RATING. IF NOT RATED, MARK N/A. *Use the parent company's rating if the applicant is a subsidiary.*

	RATING	DATE
Moody's Investors Service		
Standard & Poor's		
Dun & Bradstreet		
Other		

APPLICATION FOR SELF-INSURANCE
AGREEMENTS

In consideration of being granted the privilege of self-insurance under the Illinois Workers' Compensation and Occupational Diseases Acts, the applicant hereby agrees:

1. To promptly pay benefits due to injured employees or their dependents in accordance with the Illinois Workers' Compensation and Occupational Diseases Acts.
2. To promptly report compensable injuries, diseases, and deaths to the Commission as required by law.
3. To promptly notify the Commission of any change in financial condition that will impact the company's ability to self-insure.
4. To immediately notify the Commission before the contemplation of liquidation, sale, or transfer of ownership is made, and to make arrangements satisfactory to the Commission for the payment of all existing liabilities.

This application should be signed and sworn to by the appropriate person or persons as stated below:

if the applicant is an individual, the owner shall sign;
if the applicant is a partnership, all of the partners shall sign;
if the applicant is a corporation, its president or vice-president and its secretary or assistant secretary shall sign.

AFFIDAVIT

State of Illinois

County of _____

Each person listed below, first being sworn on oath, deposes and states that he or she is acquainted with the affairs of this applicant employer, including the representations and statements set forth in this application; that he or she has read said application and all documents submitted, knows their contents, and verifies that the representations and statements are true in substance and in fact.

_____
Applicant's legal name

_____
Signature of affiant and Date

_____
Name and title of affiant

_____
Signature of affiant and Date

_____
Name and title of affiant

Subscribed and sworn to before me

on _____

_____
Notary public

APPLICATION FOR SELF-INSURANCE
LIST OF ATTACHMENTS

A. A nonrefundable application fee of $500 for each separate legal entity applying for the self-insurance privilege.

B. Evidence of each applicant's current experience modification factor. Explain if factor is greater than one.

C. An organizational chart showing the hierarchical position of all corporate entities, including the ultimate parent. Note the percentage of ownership and clearly indicate which entities with operations in Illinois are seeking coverage under the certificate of self-insurance.

D. (1) If the applicant has an ultimate parent, provide the ultimate parent company's audited financial statements for the most recent three years.

(2) If the applicant has no ultimate parent, provide the applicant's audited financial statements for the most recent three years.

(3) If certified audited financial statements are not prepared, provide the financial statements prepared by an outside accountant for the most recent three years.

E. Provide the most current 10-Q or internal quarterly balance sheet and income statement of applicant and parent.

F. Copies of the applicant's excess insurance quotations. (A copy of the excess policy must be submitted if the application is approved.)

G. Evidence of the applicant's current workers' compensation coverage. *See question 11.*

H. Detailed Illinois loss runs for each applicant for the last three completed years. *See question 13.*

I. A narrative description of the safety program components for each operation in Illinois. *See question 17.*

J. Provide an explanation of workers' compensation insurance being refused or cancelled, if applicable. *See question 20.*

K. Provide an explanation of application for self-insurance being denied or revoked, if applicable. *See question 21.*

L. A list of all other self-insured jurisdictions, if applicable. *See question 22.*

ALL OF THE ABOVE-MENTIONED ITEMS MUST BE SUBMITTED BEFORE A REVIEW OF THE APPLICATION MAY BE COMPLETED.

SUBMISSION OF AN INCOMPLETE APPLICATION MAY DELAY THE REVIEW PROCESS.